MTS

INCORPORATED

SUMMARY PLAN DESCRIPTION

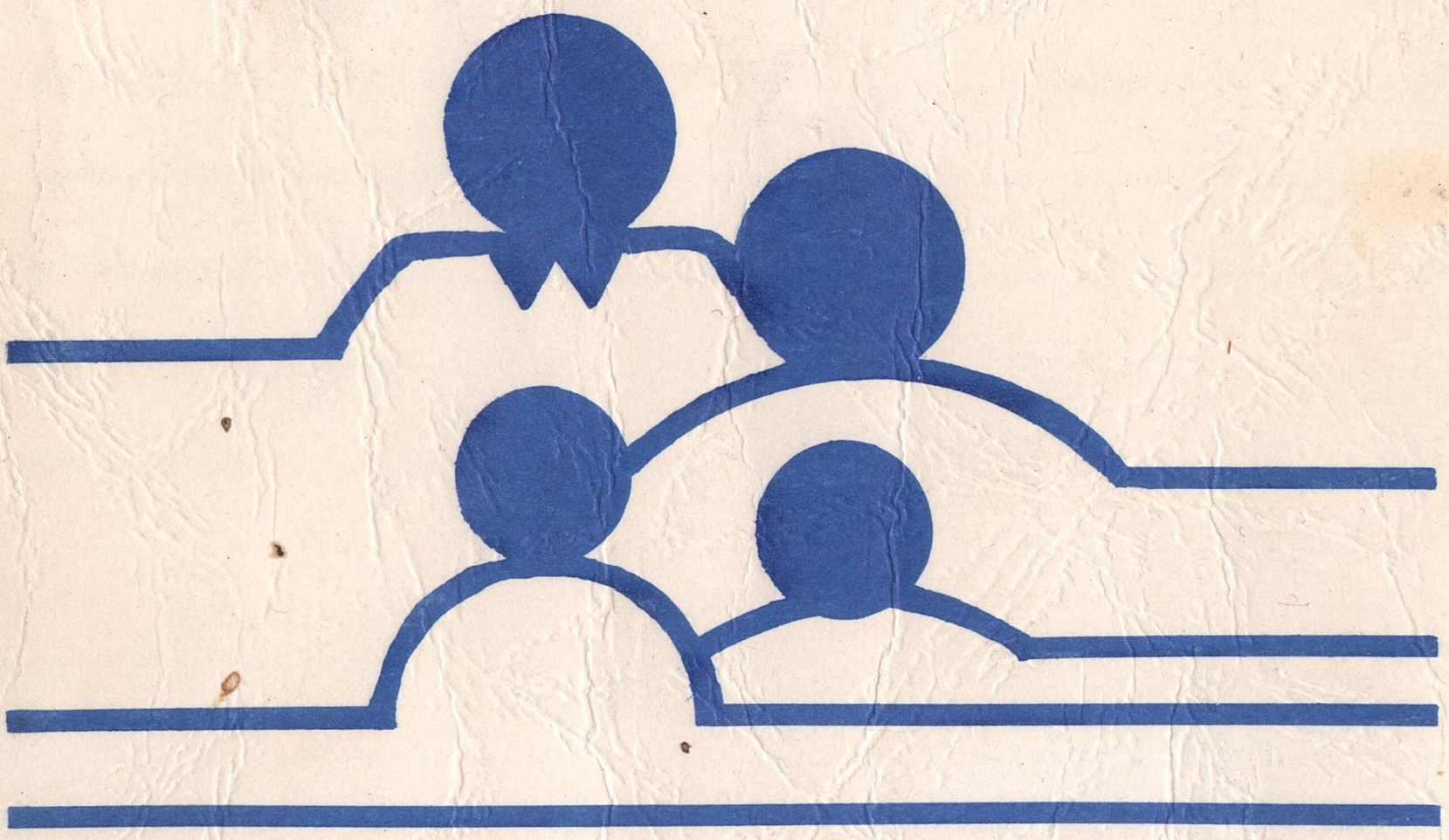

TABLE OF CONTENTS

GENERAL INFORMATION 1

LIFE and AD&D BENEFITS 7

Summary of Benefits 9

Life Insurance for Employees 10

Life Insurance for Dependents 12

AD&D Benefits 13

COMPREHENSIVE/MAJOR MEDICAL BENEFIT 15

Health Care Review Service (HCRS) Special Provision 17

Summary of Benefits 20

Deductible Information 21

Points to Note 22

Covered Expenses 23

Medical Charges 24

Hospice Care Benefit 27

Exclusions 30

DENTALCARE BENEFITS 31

Summary of Benefits 33

Deductible Information 34

Treatment Plan 34

Covered Expenses 35

Exclusions 36

TABLE OF CONTENTS (Continued)

ADMINISTRATIVE INFORMATION 38

Eligibility 40

Coverage for Your Family 41

Changes In Amount of Coverage 42

Co-ordination of Benefits (COB) 43

Special Provision for Covered Persons
Who Have Reached Age 65 46

General Limitations 47

Termination of Coverage 47

COBRA Health Continuation 48

Health Conversion Privilege 50

Continuation of Benefit Payments 51

How to File Your Claims 52

GENERAL INFORMATION

GENERAL INFORMATION

1. Name of Plan:

   Tier I Health and Welfare Plan for employees of MTS, Incorporated.

   Tier II Health and Welfare Plan for employees of MTS, Incorporated is described in a separate booklet.

2. Policyholder/Employer:

   MTS, Incorporated
   2500 Del Monte
   West Sacramento, CA 95691

3. (a) Employer Identification Number (EIN) assigned for this Plan by IRS: 94-1500342

   (b) Plan number assigned by the Policyholder/Employer: 501

4. Type of Plan:

   Life Insurance, Accidental Death, Dismemberment and Loss of Sight Insurance, Hospital, Medical and Dentalcare Benefits

5. Funding:

   The Life and Accidental Death, Dismemberment and Loss of Sight Insurance are completely funded by the Great-West Life Assurance Company.

   The Employer completely funds the Hospital, Medical and Dentalcare Benefits referred to in 4. above.

6. Type of Administration:

   Employer funded portion of the Plan - Administrative Services Only

   Great-West Life funded portion of the Plan - Contract Administration

7. Plan Administrator:

   Plan Administrator
   MTS, Incorporated
   2500 Del Monte
   West Sacramento, CA 95691

8. Agent for service of legal process:

Plan Administrator (see page 3)

9. The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility or denial or loss of any benefits are described in this booklet.

10. The source of contributions to the plan:

Employee Coverages - 100% Employer
Dependent Coverages -
Employee: $10 per month medical
$ 5 per month for dental
Employer: Employer pays the balance

Please Note:

Additional dependent contributions will be assessed during an approved leave of absence which exceeds 30 days.

11. The date of the <u>end</u> of the year for purposes of maintaining the plan's fiscal records:

December 31

12. Claims - The procedures to be followed in presenting claims for benefits under the plan and the remedies for the redress of claims which are denied in whole or in part are described in this booklet.

13. Statement of ERISA Rights:

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

(i) Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all plan documents, including contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

(ii) Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

(iii) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g. if it finds your claim is frivolous). If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

LIFE

AND

ACCIDENTAL DEATH DISMEMBERMENT

BENEFITS

SUMMARY OF BENEFITS
Life and AD&D Insurance
(Funded by Great-West Life)

EMPLOYEES

Life Insurance*	$ 4,000
AD&D Insurance (Principal Sum)*	4,000

* Your amounts of Life and AD&D Insurance shall each reduce by 35% at age 65.

DEPENDENTS

Life Insurance

Spouse	$ 1,500
Children who are:	
over 14 days but less than 6 months	100
six months and over	1,000

LIFE INSURANCE FOR EMPLOYEES
(Funded by Great-West Life)

* In the event of your death from any cause whatsoever your beneficiary will be paid your group Life Insurance. (See the Summary of Benefits at the front of this booklet for the amount.)

* If, while this plan is in force, your insurance terminates, or reduces due to retirement or change in age, you may apply for an individual life insurance policy (one of the standard conversion policies offered by Great-West Life) without taking a medical examination.

* If you have been insured under this plan for at least 5 years, you may also apply for an individual policy if the group policy terminates or if the plan is amended to reduce your amount of insurance.

* You must apply for an individual policy within 31 days after such termination or reduction of your insurance.

* During this 31-day period, your life insurance remains in force free of charge.

* Should you become totally disabled while insured and before reaching the age of 60, and such disability continues without interruption for at least six months, your life insurance will remain in force without further premium payment as long as your disability continues. If, however, your disability commences on or after your 60th birthday but prior to your 70th birthday, your life insurance will still be continued without premium payment as long as your disability continues, but only until the earlier of the following dates:

  (i) the date on which your insurance has been continued without premium payment under this provision for a period of 5 years, or

  (ii) the date on which you attain your 70th birthday.

* The amount of insurance being continued under this provision will be the amount for which you were insured on the date your disability commenced but this amount will also be subject to any reductions and/or terminations due to age or retirement which were in effect under this plan on that date. If your disability ends or your insurance reduces or terminates due to age or retirement while being continued under this disability provision, you may apply for an individual policy of life insurance as described in the above paragraphs.

* If you are totally disabled when the group policy terminates or the insurance for the particular subsidiary your work for terminates and your insurance is not being continued in accordance with the provisions of the above paragraph, you may apply for an individual policy of life insurance in the same way as you would if your insurance had terminated while the group policy was still in force or your subsidiary was still insured.

LIFE INSURANCE FOR DEPENDENTS
(Funded by Great-West Life)

* In the event of your dependent's death from any cause whatsoever, the insurance company will pay you the amount for which he or she was insured. (See the Summary of Benefits at the front of this booklet for the amounts.)

* Should you leave your employer or die while this plan is still in force, your spouse may apply for an individual policy (one of the standard conversion policies offered by Great-West Life) without taking a medical examination.

* Your spouse may also apply for an individual policy in the event that all or part of his or her insurance coverage terminates as a result of any amendment to this plan or as a result of termination of this plan, but only if he or she has been insured under this plan for at least 5 years prior to the date of termination.

* He or she must apply for an individual policy within 31 days after the termination of insurance.

* During this 31-day period your spouse's insurance remains in force free of charge.

Dependents Covered

If you elect this benefit, your dependents eligible for Life Insurance are:

. Your spouse

. Your children (between 14 days and 21 years, and for whom you are entitled to an income tax exemption)

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT INSURANCE (Funded by Great-West Life)

Should you suffer the loss of life, limb or sight as the result of an accident, the insurance company will pay up to the "Principal Sum". (The Principal Sum is listed in the Summary of this booklet.)

The Principal Sum will be paid for loss of:

* Life
* Both hands or both feet
* Sight of both eyes
* One hand and one foot
* One hand or one foot and sight of one eye

One-half of the Principal Sum will be paid for loss of:

* One hand or one foot
* Sight of one eye

Points to Note about AD&D Insurance

* The Principal Sum is the maximum amount that would be paid for injuries to any one person resulting from any one accident. This means that if an employee were to lose both hands and both feet in an automobile accident, he would receive the Principal Sum only, not double the Principal Sum.

* AD&D Insurance would not be paid in the event of injury or death resulting from intentional self-mutilation, suicide, ptomaine poisoning, bacterial infection, war or any act incident thereto.

* AD&D Insurance will not be paid if loss of life, limb or sight occurs more than 90 days after the accident.

* For the purposes of this AD&D Insurance "loss" means complete loss by severance except that in the case of loss of sight it means loss of sight beyond remedy by surgical or other means.

EMPLOYER FUNDED BENEFITS

Your Employer provides Hospital/Medical/Dental Benefits under his Health Care Payment Plan. These benefits are fully funded by your Employer. Great-West Life provides only administrative services for these expenses. A description of each of the Employer funded benefits follows.

COMPREHENSIVE/MAJOR MEDICAL BENEFIT

HEALTH CARE REVIEW SERVICE (HCRS)
SPECIAL PROVISION

This plan includes the Health Care Review Service (HCRS) program. This means that subject to all other provisions of the plan; HCRS will review each proposed hospital admission, and each proposed surgical procedure which is to be performed outside the doctor's office (excluding minor first aid) and will determine and authorize:

* the medical necessity of such treatment;

* the appropriate location for such treatment to be provided; and

* in the case of a hospital admission, the length of stay for each in-patient hospital confinement.

HCRS must be contacted:

* in advance of treatment being rendered; or

* in the case of an emergency, by the end of the next regular work day following the date the emergency treatment begins.

The term "emergency" means:

* an accident which required immediate treatment; or

* a "life threatening" illness which requires immediate treatment at a hospital. The doctor who attends the covered person must certify that the illness was "life threatening".

If HCRS is not contacted as described above, then expenses related to a hospital admission or out-patient surgery will be subject to the HCRS Deductible shown in the Summary of Benefits.

This deductible:

* is in addition to any other deductible under the plan; and

* will not be used to satisfy the Break Point.

HEALTH CARE REVIEW SERVICE (HCRS)
SPECIAL PROVISION (Continued)

If the covered person:

* does contact HCRS as indicated above, but does not follow the HCRS authorization; or

* does not contact HCRS as indicated above;

then the claim may be reviewed by HCRS after it is received by Great-West Life to determine which expenses, if any, are not eligible for payment under the plan.

Ineligible Expenses:

If certain in-patient days are determined by HCRS to be not medically necessary, then the hospital room and board charges for those days will be considered ineligible expenses.

If the facility in which an out-patient surgery is performed is determined by HCRS to be not medically necessary in relation to the level of care received, then the facility charge will be considered an ineligible expenses.

If the treatment received is determined by HCRS to be not medically necessary, then all treatment services or supplies related to such treatment will be considered to be ineligible expenses.

Ineligible expenses for any hospital admission or out-patient surgical procedure, up to the HCRS Ineligible Expense Maximum Amount shown in Summary of Benefits, will not be reimbursed under the plan.

Ineligible expenses not reimbursed under the plan will not be used to satisfy the plan deductible or the Break Point.

The HCRS Ineligible Expense Maximum Amount does not apply to the limitations and maximums which apply to each separate benefit.

For example, the HCRS Ineligible Expense Maximum Amount will not apply to cosmetic surgery, experimental procedures or other such treatment which is specifically excluded under the plan.

HEALTH CARE REVIEW SERVICE (HCRS)
SPECIAL PROVISION (Continued)

Second Opinions:

HCRS may require a second opinion before granting pre-authorization for expenses incurred for certain medical or surgical treatment. In this case, these expenses:

* will not be subject to the plan deductible; and

* will be payable at 100%.

Alternate Care and Treatment:

Alternate forms o care and treatment may be recommended by HCRS as part of its Prior Authorization or Catastrophic Claims Management (CMM) programs. HCRS may from time to time suggest the use of alternate treatment plans or alternate treatment facilities such as Home Health Care or Hospice Care which are not included in the plan, or are included under the plan but on a basis that differs from the care and treatment now recommended by HCRS. When this happens, subject to approval of the covered person and the covered person's:

* family; and

* attending doctor;

these expenses will be payable under the plan on the same basis as the care and treatment for which they are substituted.

SUMMARY OF BENEFITS
for
EMPLOYEES and DEPENDENTS

HCRS Special Provision	
HCRS Deductible	$ 250.00
HCRS Ineligible Expense Maximum Amount	1,000.00
Comprehensive/Major Medical Benefits	
Calendar Year Deductible (per person)	$ 100.00
Calendar Year Deductible (per family)	300.00
Co-Payment Percentage for:	
-confinement in a childbirth center	100%
-visits to a doctor's office	80%
-all other covered expenses	50% to $4,000 then 100% thereafter in any one calendar year
Covered Expense limits:	
Benefit maximum for each visit to a doctor's visit	$ 50.00
Hospital Daily Amount (Room & Board)	the usual charge of the hospital concerned for semi-private care
Intensive Care Daily Amount	the usual charge of the hospital concerned for confinement in an Intensive Care Unit
Extended Care Room and Board	see description on page 25
Lifetime Maximum (All Covered Expenses)	$500,000.00

COMPREHENSIVE/MAJOR MEDICAL BENEFIT

The Comprehensive/Major Medical Benefit is designed to assist you with the payment of your larger hospital/medical bills. It does not pay the total cost of hospital/medical services and supplies. In effect, the plan shares with you the payment of your hospital/medical bills. The Comprehensive/Major Medical Benefit covers only those expenses which are considered reasonable and customary for the service provided in the area where the expenses are incurred, and which are in excess of benefits available under other parts of this plan.

* The plan pays 100% of covered expenses for confinement in a childbirth center.

* You pay the first $100 ($100 "deductible") of covered expenses and 50% of the remainder until you have incurred $4,000 ("Break Point") of covered expenses in any one calendar year. Any covered expenses which are in excess of $4,000 "Break Point" in a calendar year are paid for by the plan at 100%.

* The $100 "deductible" is paid only once in any one calendar year for any one person.

* The $100 "deductible" is paid only once if two or more family members incur expenses as a result of the same accident.

* In any event, not more than $300 would be paid in deductible amounts by any one family in any one calendar year.

* So that you will not have to pay the deductible twice in a short period for the same person, any expenses applied against it in the last three months of a calendar year may also be applied against the deductible for the next calendar year.

Points to Note About
The Comprehensive/Major Medical Benefit

* The Lifetime Maximum Comprehensive/Major Medical benefit for each person is $500,000.

* Confinement in a child-birth center will be considered a covered expense if such center:

(a) is licensed by the department responsible for the licensing of such facilities in the geographical area in which it is located, and

(b) has permanent facilities which are equipped and operated mainly for child-birth, and

(c) provides continuous service by physicians, registered nurses or midwife nurse practitioners when a patient is in the center.

(d) in those geographic areas that do not have birthing center facilities which meet the criteria outlined above, birth center benefits will be provided if all of the following conditions are met:

1. care for routine delivery is rendered in a hospital; and

2. confinement in the hospital after delivery is for 30 hours or less; and

3. the patient does not receive a bill for regular hospital room and board charges for any part of the day on which a charge is made for the birth center. For the purposes of birth center billing, any charge made by the hospital for a recovery room, or after birth "rest" room, will be considered birth center charges and not hospital room and board charges.

* If you or one of your dependents is treated for an injury or sickness within 30 days before the date coverage becomes effective, no benefits will be payable for services and supplies received in connection with that condition unless such services and supplies are received after the earliest of the following dates:

(1) the last day of a 30-day period during which no hospital/medical expenses were incurred in respect of the condition, or

(2) in respect of your expenses only, the date on which you have completed 3 consecutive months of active full-time work while covered for Comprehensive/Major Medical benefits, or

(3) in respect of expenses incurred by either you or your dependent, the date on which you or your dependent has been covered by Comprehensive/Major Medical benefits for twelve consecutive months.

Covered Expenses

The following services and supplies are covered by your Comprehensive/Major Medical Benefit:

Hospital Charges

* Regular hospital room and board (up to the usual daily charge of the hospital concerned for semi-private care)

* Intensive hospital care (up to the usual daily charge of the hospital concerned for confinement in an Intensive Care Unit)

* Confinement in an Extended Care Facility (semi-private rate of the Extended Care Facility) up to the following maximums during any one Benefit Period:

(a) for each of the first 60 days, 50% of the semi-private rate of the last hospital in which you were confined prior to your admission into the Extended Care Facility, and

(b) for each of the next 30 days, 25% of such hospital's semi-private rate.

Please Note: Expenses for confinement in an Extended Care Facility will be covered only if:

(1) recommended by your physician,
(2) they are not incurred for custodial care, and
(3) the confinement follows within 7 days after a 3-day confinement in a hospital as a registered bed-patient and is for the same condition.

Successive periods of confinement in an Extended Care Facility will be considered to be in the same Benefit Period unless, in the case of an employee, he returns to work for two full weeks between confinements or the later confinement is necessary as the result of an entirely different disability. For dependents, successive periods of confinement in an Extended Care Facility will be considered to be in the same Benefit Period unless the later confinement begins after the dependent has not been in either a hospital or an Extended Care Facility for 3 consecutive months or unless the later confinement is necessary as the result of an entirely different disability.

* Other hospital services and supplies

Medical Charges

* Doctor's services (payable at 80% co-payment up to a maximum of $50 per visit)

* Anesthesia

* X-ray treatment

* Oxygen

* Blood transfusions

* Prescription drugs and medicines (excluding drugs used for contraceptive purposes)

* Insulin, insulin syringe and clinitest

* X-rays and lab tests

Medical Charges (Continued)

* Services of a registered nurse

* Services of a licensed practical nurse

* Services of a physical therapist

* Occupational therapy and speech therapy while confined in hospital

* Reconstructive surgery incident to a mastectomy performed on or after July 1, 1980 including prosthetic devices when prescribed by a physician

* Rental of wheel chair, bed rail, hospital bed or iron lung

* Ambulance

* Splints, trusses, orthopedic braces, crutches, casts, artificial limbs and eyes

* Head halter or other traction apparatus

* Cervical collar, colostomy bag, ileostomy supplies and catheters

* Dental surgery

* Well Newborn care for a newborn infant while confined in a hospital for up to the first 7 days of its life. This includes routine nursery charges, charges for Doctors' fees and PKU tests

* Well baby for children under one year of age

* Chiropractic treatment - subject to the reasonable and customary guidelines. For specific benefit information contact the claims office.

* Abortions

* Tubal ligations

* Vasectomies

* Mammography if recommended by your doctor. This includes:
  (a) a baseline mammogram for women age 35 to 39 inclusive;
  (b) a mammogram for women age 40 to 49 inclusive, once every 2 years or more frequently if recommended by your doctor;
  (c) annual mammogram for women age 50 or over.

Medical Charges

* Dental services rendered by a physician, dentist or oral surgeon for treatment of fractured jaw or of accidental injuries to natural teeth within 6 months after the accident; alveoloplasty or alveolectomy (area occupied by not less than six teeth per jaw); treatment of cellulitis; excision of soft tissue lesion of oral cavity; biopsy; excision of tori; excision of benign hard tumor (osteoma); radicular or dentigerous cyst; closure of oro-antral fistula; removal of salivary stone from duct or gland; therapeutic nerve block with alcohol or other sclerosing solutions; surgical removal of impacted teeth.

Pregnancy

* The Comprehensive/Major Medical Benefit pays for hospital and medical expenses related to pregnancy for female employees and dependents in the same way as it would for any other type of disability.

Hospice Care Benefit

* The plan will pay for the care of a terminally ill employee or dependent. Terminally ill means that the patient has a life expectancy of 6 months or less as certified by the attending physician. Covered Expenses include:

(1) "Hospice Care In-patient Covered expenses" up to 180 days. This means such charges by a hospice for confinement as an in-patient:

(a) for room and board during such confinement; and
(b) for Hospice Services furnished under a Hospice Care Program.

(2) "Hospice Care Out-Patient Covered Expenses" up to the reasonable and customary charges incurred during any one benefit period. A benefit period begins when the attending physician certifies the employee or dependent is terminally ill and ends six months later or when the person dies if earlier. These expenses are incurred for Hospice Services rendered on an out-patient basis.

(3) "Bereavement Covered Expenses" means expenses incurred by all members of the family for supportive services provided to them after the death. Such charges will be payable up to three months following the death and up to a maximum of $100.

"Hospice Services" means all services and supplies other than room and board furnished to the terminally ill person or to this family through a Hospice Care Program.

"Hospice Care Program" means a formal program directed by a Doctor to help care for a terminally ill person. This program is through either:

(A) a centrally-administered and nurse-coordinated program which:

(a) provides a coherent system primarily of home care;
(b) uses a Hospice Team;
(c) is available 24 hours a day, seven days a week, and
(d) provides bereavement services;

or

(B) confinement in a Hospice.

The Hospice Care Program:

(a) includes special care rendered for the:
(i) physical;
(ii) psychological;
(iii) spiritual; or
(iv) social

needs of terminally ill people and their families.

(b) must meet the standards set by the National Hospice Organization. If such Program is required by a state to be licensed, certified or registered, it must also meet that requirement to be considered a Hospice Care Program.

"Hospice Team" means a team of professional and volunteer workers who provide care to:

(A) reduce or abate pain or other symptoms of mental or physical distress;
(B) meet the special needs arising out of the stresses of terminal illness, dying and bereavement.

A Hospice Team must include:

(a) a Doctor; and
(b) a registered graduate nurse.

It may also include any of the following:
(i) a social worker
(ii) a clergyman/counselor;
(iii) a clinical psychologist;
(iv) a physical therapist; or
(v) an occupational therapist.

"Hospice" means a facility which provides short periods of in-patient confinement for a terminally ill person in a home-like setting for either direct care or respite. This facility:

(A) may be either free-standing or affiliated with a Hospital;
(B) must operate as an integral part of the Hospice Care Program; and
(C) must provide care for at least 2 but no more than 8 persons who are:
    (a) not related;
    (b) terminally ill; and
    (c) confined a in-patients.

"Family" means the terminally ill person's:
(A) legal spouse;
(B) children; and
(C) parents

Members of a family need not be insured under this plan to receive benefits for Bereavement Covered Expenses.

Exclusions Under the Comprehensive/Major Medical Benefit

* Eyeglasses and hearing aids

* Injury or illness due to war

* Dental services, except those listed under Medical Charges described earlier in this booklet (see Dentalcare Benefit for other services covered)

* Cosmetic surgery, hospital confinement or any other service associated with cosmetic surgery, except to correct deformities resulting from illness or injury or such congenital defects as interfere with function

* Routine eye and hearing tests

* Routine medical examinations for a covered person over one year of age.

* Inpatient and Out-patient Treatment for a Mental/Nervous, Substance Abuse and Alcoholism condition

DENTALCARE BENEFITS

SUMMARY OF BENEFITS
for
EMPLOYEES AND DEPENDENTS

Dentalcare Benefits

Calendar Year Deductible (per person)	$ 50.00
Calendar Year Deductible (per family)	$ 150.00
Co-Payment percentage for:	
Routine Treatment	80%
Annual Maximum	$1,000.00
Adjusted Annual Maximum	500.00

DENTALCARE

Dentalcare has been designed to help you pay for your family's dental expenses, both for routine care and for expensive and unforeseen treatment.

Dentalcare covers only those dental expenses which are considered reasonable and customary for the service provided in the area where the expense is incurred, and which are in excess of benefits available under other parts of this plan.

* You pay the first $50 (the "deductible") of covered expenses for Routine Treatment. The plan then pays 80% ("percentage") of the balance of expenses.

  Please Note: The deductible will not be applied to any expenses incurred solely as the result of accidental injury to natural teeth.

* The "deductible" is paid only once in any one calendar year for any one person. However, if a course of Dental Treatment for which the estimated cost is $300 or more continues into the next calendar year, the deductible will be applied only once for the complete Course of Treatment.

* Not more than $150 will be required in deductible amounts for any one family in any one calendar year.

* The maximum amount that the plan will pay in any one calendar year is $1,000 for any one person. This maximum is reduced to $500 during the first year a person is covered if his coverage commences on or after July 1 of any year.

Treatment Plan

* Before your dentist starts a course of treatment, he will, upon request, prepare a "treatment plan"-a written report describing his recommendations as to necessary treatment and cost.

Treatment Plan (Continued)

* You should submit a "treatment plan" before treatment commences for any Routine Treatment expected to cost more than $300. The plan's share of the cost of the proposed treatment can then be determined in advance so that you can be advised of the extent of any part of the cost which you have to pay.

* If you do not submit a "treatment plan" where required, your claim may be refused.

  Note: If the proposed course of treatment does not commence within 90 days, a new treatment plan will be required before benefits will be paid.

Covered Dental Services and Supplies

Routine Treatment

* oral examinations, cleaning teeth, topical application of fluoride solutions for individuals under 18 years of age and bite-wing x-rays, twice in any calendar year but not more than once in any 5-month period.

* full-mouth series of x-rays once every 24 months

* extractions and alveolectomy at the time of tooth extraction

* dental surgery

* amalgam, silicate, acrylic and composite fillings

* necessary treatment for relief of dental pain

* cost of medication and its administration when provided by injection in the dentist's office

* space maintainers for missing primary teeth and habit-breaking appliances

Routine Treatment

* general anesthesia and diagnostic x-ray and laboratory procedures required in relation to dental surgery

* consultations required by the attending dentist

* denture relines and rebases

* endodontics (root canal therapy)

* periodontic treatment

Exclusions

Covered dental expenses do not include and no payment is made for:

* treatment furnished without charge or paid for directly or indirectly by any government or for which a government prohibits payment of benefits

* cosmetic treatment, experimental treatment, dietary planning, plaque control, oral hygiene instructions, treatment for the correction of any congenital or developmental malformation

* expenses not recommended or prescribed by a dentist or physician

* treatment received from a dental or medical department maintained by the employer, a mutual benefit association, labor union, trustee or similar type of group.

* expense of dentures which have been lost, mislaid or stolen

Exclusions (Continued)

* expense of dental treatment required as a result of any self-inflicted injury, war or of engaging in a riot or insurrection

* charges made by a dentist for broken appointments or for completion of claim forms required by the plan

* orthodontic treatment

* charges for dental treatment involving the use of gold which are in excess of the charges that would have been made if a reasonable substitute could have been used

* expense of dental treatment (i. e. dental surgery, periodontal surgery or treatment of accidental injuries to natural teeth within 6 months after an accident) for which coverage is provided under the Comprehensive/Major Medical Benefit described earlier in this booklet

* crowns and fixed bridge restorations including replacement and repair

* partial or complete dentures including denture replacement and repair

ADMINISTRATIVE INFORMATION

ELIGIBILITY

If you are a new employee, coverage will become effective on the first of the month next following or coinciding with the date that you have completed one month of continuous, full-time employment.

Please Note

Refer to the employee packet distributed by your Manager for further details.

* Temporary and part-time employees who work under 30 hours per week may not join the plan. Hourly employees already insured under the plan, who drop below 30 hours per week will no longer be eligible for benefits. To resume coverage, they will be recognized as a new employee and must complete a new eligibility period.

* You, as an employee, will be covered by the plan automatically as soon as you become eligible.

* Dependent coverages which require a contribution on your part may require proof of good health if not applied for within one month of the date on which you or your dependents become eligible.

* If Dentalcare coverage becomes effective more than 31 days after the date the dependent(s) was first eligible for coverage, then the plan will pay up to $250.00 the first twelve months of coverage from the Effective Date of coverage for that person(s).

* If you are away from work on the date when your coverage would normally start, it will not become effective until you return to work.

* If you receive late applicant approval for your medical benefits then your dependent will be eligible for the "limited" dental benefits. The plan will pay up to the first twelve months.

COVERAGE FOR YOUR FAMILY

If you elect to cover your dependents, the Health Care Payment Plan will also cover:

* Your spouse

* Your unmarried children (under 21 years, who are chiefly dependent on you for support and for whom you are entitled to an income tax exemption)

* Your unmarried children who are registered students in full-time attendance at a university or similar institution of learning (who may be 21 or over but who are chiefly dependent on you for support and for whom you are entitled to an income tax exemption)

* Your unmarried children who are physically handicapped or mentally retarded (who may be 21 or over but who are chiefly dependent on you for support), provided such child was covered under this plan immediately prior to his or her 21st birthday.

Please Note

* If you are currently covered as a single employee, you may add your newborn child to the plan without penalty. You must make application to cover the newborn child as a dependent within 31 days after the birth of the child.

* If coverage is requested for spouse, newborn child, or any other eligible dependents after 31 days from their eligible effective date, the dependents will be considered late applicants and must satisfy proof of good health. For late applicants, the effective date of coverage will be the date of approval of the proof of good health by Great-West Life on behalf of the planholder.

* If your spouse or child is in hospital when your coverage becomes effective, he or she is not covered by the plan until released from hospital.

CHANGES IN AMOUNTS OF COVERAGE

Any changes in your amounts of coverage resulting from a change in the factors on which these amounts are based (e.g. age, classification, earnings, etc.) or resulting from any amendment which revises the amounts and/or benefits provided under the plan will become effective on the date of the change. For any change which results in increased benefits, you must be actively at work otherwise the change will not become effective until the date of your return to work. If one of your dependents is confined in hospital on the date an increase in your dependents' benefits would otherwise become effective, the increase for that dependent will not become effective until he or she is released from hospital. In any case, payment for expenses incurred by you or one of your dependents for services and supplies received before the date of an increase in benefits will be made on the basis of the plan provisions which were in effect before the change.

CO-ORDINATION OF BENEFITS (COB)

The COB provision is designed to correct the overcoverage problem which occurs when a person has health coverage for the same expenses under two or more of the plans listed below. Should this type of duplication occur, the benefits under the Plan will be co-ordinated with those of the other plans so that the total benefits from all plans will not exceed the expenses actually incurred. COB affects all health coverages in which duplication occurs.

The benefits provided by the plans listed below are considered in determining duplication of coverage:

(a) This Plan:

(b) Any other group insurance or prepayment plan, Health Maintenance Organizations (HMO's); Blue Cross/Blue Shield;

(c) Any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan;

(d) Any government plan or statute providing benefits for which COB is not prohibited by law.

ORDER OF BENEFIT DETERMINATION

Certain rules are used to determine which of the plans will pay benefits first. This is done by using the first of the following rules which applies:

(a) A plan with no COB provision will determine its benefits before a a plan with a COB provision.

(b) A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers such person as a Dependent.

(c) When a claim is made for a Dependent child who is covered by more than one plan;

(i) the benefits of the plan of the parent whose birthday falls earlier in a year will be determined before the benefits of the plan of the parent whose birthday falls later in the year; but

(ii) if both parents have the same birthday, the benefits of the plan which covered the parent longer will be determined before those of the plan which covered the other parent for a shorter period of time.

This method of determining the order of benefits will be referred to as the "Birthday Rule". The Birthday Rule will be used to determine the order of benefits for dependent children in all cases except those described below:

1. If the other plan does not have the Birthday Rule, then the plan which covers the child as a dependent of the male parent will pay its benefit first.

2. If the parents are legally separated or divorced, benefits for the child will be determined in this order:

   (a) first, the plan of the parent with custody of the child will pay its benefits;

   (b) then, the plan of the spouse of the parent with custody of the child will pay its benefits; and

   (c) finally, the plan of the parent not having custody of the child will pay its benefits.

   However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child is a dependent of that parent will determine its benefits before any other plan.

(d) A plan that covers a person as:

   (i) a laid-off Employee; or
   (ii) a retired Employee; or
   (iii) a Dependent of such Employee;

will determine its benefits after the plan that does not cover such person as:

1. a laid-off Employee; or
2. a retired Employee; or
3. a Dependent of such Employee

If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

(e) If none of the above rules establishes the order of payment, a plan under which the person has been covered for the longer time will determine its benefits before a plan covering that person for a shorter time.

Two successive plans of the same group will be considered one plan if the person was eligible for coverage under the new plan within 24 hours after the old plan terminated. A change in the amount or scope of benefits, or a change in the carrier, or a change from one type of plan to another (e.g. single employer plan to multiple employer plan) will not constitute the start of a new plan.

When the COB provisions reduces the benefits payable under this Plan:

(i) each benefit will be reduced proportionately; and
(ii) only the reduced amount will be charged against any benefit limits under this Plan.

The COB provision is applied throughout the calendar year. If there is any reduction of the benefits provided under a specific benefit provision of this plan because of duplicate coverage, similar benefits may be payable later in that year if more allowable expenses are incurred under the same benefit provision. "Allowable expense" means any necessary, reasonable and customary item of expense at least part of which is covered under at least one of the plans covering the person for whom claim is made on service provided. In no event will allowable expense include the difference between the cost of a private hospital room and a semi-private hospital room unless the patient's stay in a private hospital room is medically necessary.

Benefits under a governmental plan will be taken into consideration without expanding the definition of allowable expense beyond the hospital, medical and surgical benefits as may be provided by such governmental plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

SPECIAL PROVISION FOR COVERED PERSONS WHO HAVE REACHED AGE 65

This provision applies to you if you are an active employee who has attained age 65. It also applies to your spouse if you are an active employee of any age and your spouse has attained age 65.

Upon attainment of age 65, you or your spouse will continue to be eligible for the benefits provided under this booklet. Benefits will be payable as otherwise provided under this booklet except that such benefits will not be reduced by any Medicare benefits to which you or your spouse is entitled solely on account of age. This means that for the purposes of the CO-ORDINATION OF BENEFITS section, the benefits payable under Medicare will be determined after the benefits under this booklet are determined.

If:

(1) you do not wish to have the benefits of this booklet payable before benefits are payable under Medicare; and

(2) you would rather have Medicare be the primary plan of benefits;

you must notify your Plan Administrator.

Please Note:

In most cases, if you elect Medicare as the primary plan of benefits, no benefits will be payable under this booklet. See your Plan Administrator for details.

PROVISION FOR COVERED PERSONS WHO ARE ELIGIBLE FOR MEDICARE ON ACCOUNT OF DISABILITY (OBRA)

This Provision applies to you if you as an active Employee or one of your eligible Dependents qualify for benefits under Medicare on account of disability. Benefits payable to which you or your eligible Dependents are entitled solely on account of disability. This means that for the purposes of the COB section, the benefits payable under Medicare will be determined after the benefits provided under this booklet are determined.

GENERAL LIMITATIONS

Your Health Care Payment Plan does not cover hospital, dental or medical services and supplies in the following situations;

* Injury sustained while working for pay or profit

* Illness for which you are covered under Workmen's or Worker's Compensation or some similar program

* Services received in a government hospital unless you are required to pay for such services

* Services to which the patient is entitled without charge, or for which there would be no charge if there were no coverage

  Please Note: If you are charged for services received in a non-governmental charitable research hospital, the above limitation will not apply.

* Services provided under any government sponsored hospital or health plan.

* Services or supplies received as a result of:
  (a) any family planning procedure which requires outside intervention, such as but not limited to artificial insemination, or in vitro fertilization;
  (b) radial keratotomy;
  (c) experimental treatment or investigational treatment or procedure; or
  (d) the reversal of any sterilization procedure.

TERMINATION OF COVERAGE

Unless otherwise specified in this booklet, coverage for yourself and/or your dependents ceases:

* On the last day of the contract month in which you leave your job or retire, or

* when the group plan expires, or

* when you stop making contributions where required.

COBRA HEALTH CONTINUATION

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and/or your dependents may qualify for continued health (medical and dental) coverage for a specified period of time after coverage would normally terminate under this plan.

Qualifying Events

In order to be eligible for such continued health coverage a qualifying event must occur which would otherwise cause a loss of coverage. Qualifying events include:

(1) termination of your employment for any reason except gross misconduct; and

(2) in the case of your dependents:

(A) your becoming eligible for Medicare;
(B) your death;
(C) divorce or legal separation;
(D) your dependents ceasing to qualify as dependents.

Notification

If coverage would otherwise be lost due to:

(1) divorce or legal separation; or
(2) your dependents ceasing to qualify as "Dependents"

then you or your dependent must notify the Plan Administrator within 60 days of the qualifying event. The Plan Administrator will then inform you of the proper election procedures and provide you with the necessary election forms.

If coverage would otherwise be lost due to any other qualifying event, then the Plan Administrator will notify you of the proper election procedures and provide you with the necessary election forms within the time periods specified by law.

Type of Coverage

The continued health coverage provided by COBRA will be the same as that provided under this Booklet for similarly situated individuals.

If this plan replaces another plan and you or your dependents were receiving benefits under COBRA from the prior plan, then benefits may be continued under this provision for the remainder of the original period. However, benefits will be reduced by any benefits which are payable under the prior plan.

Maximum Period of Continuation

Dependent on the qualifying event, health benefits may be continued for up to 18 or 36 months after coverage would otherwise terminate.

If your coverage or your dependents' coverage would otherwise be lost due to termination of your employment for any reason except gross misconduct, then coverage may be continued for up to 18 months.

Please Note: If a second qualifying event occurs during this period, coverage may be extended for an additional 18 months.

If your Dependents' coverage would otherwise be lost due to:

(1) your becoming eligible for Medicare; or
(2) your death; or
(3) your divorce or legal separation; or
(4) your dependents ceasing to qualifying as dependents;

then coverage may be continued for up to 36 months.

However, in all cases, benefits will terminate earlier if the plan terminates or if the person receiving continued benefits:

(1) fails to pay any required contributions on time; or
(2) becomes covered under another group plan; or
(3) becomes eligible for Medicare.

Should you have any questions about COBRA continuation, see your Plan Administrator for details.

COBRA HEALTH CONTINUATION (Continued)

If you or your dependents are totally disabled on the date the Period of Cobra Health Continuation ends due to any reason, you or your dependents will be entitled to extended benefits under the Continuation of Benefit Payments section of the plan (see page 51).

When the Maximum Period of Continuation ends due to expiration of the Period, you and/or your dependents will be entitled to exercise the conversion privilege contained in the plan.

HEALTH CONVERSION PRIVILEGE

If your coverage terminates while the Plan is in force you may be entitled to convert your group coverage to an individual hospital and medical insurance policy (available from the Great-West Life Assurance Company at your expense) provided you have been covered under the group plan for at least 90 days. Your spouse and children may also be entitled to convert to an individual policy under certain circumstances. If you are entitled to convert your group coverage for yourself and your dependents you must do so within one month of termination. For complete details of the conversion privilege (i.e. who is eligible to convert, what benefits are provided by the individual policy, who is covered under the individual policy, when the individual policy becomes effective, cost, etc.) contact your plan administrator.

CONTINUATION OF BENEFIT PAYMENTS

For Comprehensive/Major Medical Benefit:

If you are totally disabled when your Comprehensive/Major Medical Benefit terminates, and you have incurred covered expenses for the disabling illness before the date of termination, the plan will continue to pay benefits for that disability after termination of coverage but only for those covered expenses which are incurred before the earliest of the following:

* the date on which your disability ceases,

* the date on which you have received maximum benefits,

* the date on which you have received benefits for a period equal in length to the period for which you were covered (not applicable in the event of termination of the group plan or termination of coverage for your particular subsidiary),

* the date which is one year from the date your coverage terminates,

* the date which you become covered under any replacement plan issued to the Employer by another carrier.

Please Note: The continuation of benefits provisions do not apply to AD&D Insurance.

HOW TO FILE YOUR CLAIMS

Life Insurance

In the event of your death the Plan Administrator named in the General Information section at the front of this booklet will contact your beneficiary to explain what is required before payment of the insurance money can be made. The Plan Administrator will provide the necessary claim forms and instructions for completing them. If prompt contact is not made by the Plan Administrator, your beneficiary should take the initiative in making contact.

The insurance money payable on your death will be paid to your beneficiary in a lump sum unless, by written notice to the insurance company, you have requested that it be payable on an installment basis as provided in the group policy or be left deposit with the insurance company. If you have not elected an alternative method of settlement, your beneficiary may elect one of the settlement options at your death.

AD&D Insurance

In the event of accidental dismemberment or loss of sight, ask your Plan Administrator for the appropriate claim forms. Ensure that these are properly completed and then return them to the Plan Administrator.

In the event of your accidental death, the Plan Administrator will explain the claim requirements to your beneficiary.

Hospital

Have the Hospital Admitting Clerk complete a Hospital Claim Report and attach their billing. Be sure this form includes the Group Plan Number. The Hospital will forward the form directly to the Benefit Payments Office shown on the next page and payment will be made directly to you or, if you so elect, to the hospital.

Medical

Ask your Doctor to complete an itemized Physician's Statement and attach his billing. Be sure the Group Plan Number is included on this form. The Doctor will forward the form directly to the Benefit Payments Office shown on the next page and payment will be made directly to you or, if you so elect, to the Doctor.

Dental

Ask your Dentist to complete a dental form (available from your Plan Administrator) and attach his billing. Be sure the Group Plan Number is included on this form. The Dentist will forward the form directly to the Benefit Payments Office shown below and payment will be made directly to you or, if you so elect, to the Dentist.

Benefit Payments Office
The Great-West Life Assurance Company
333 Market Street, Suite 830
San Francisco, CA 94105

Please Note:

If you wish to have benefit payments paid directly to your doctor, dentist or hospital, complete the "assignment" portion of the claim form.

Written proof of loss for which a claim is being made must be submitted to the Plan Administrator within 90 days after the date of loss, if reasonably possible. If it is not reasonably possible to submit proof within this time, it will still be accepted beyond the 90-day period as long as it is submitted as soon as reasonably possible but not later than one year after the end of the original 90-day period.

NOTICE OF DENIAL OF CLAIM

If any benefits are denied, either in whole or in part, notification of the specific reason or reasons for the denial will be given along with reference to the pertinent plan provisions on which the denial is based. Guidance as to the additional material or information required to perfect the claim will also be given.

Notice of any decision denying the claim must be furnished within 90 days after the claim is filed. If special circumstances require an extension of time to act on the claim, another 90 days will be allowed. If such an extension is required, notification will be given by the Plan Administrator before the end of the initial 90-day period. If the claim is not processed or a notice is not given within these time periods, the claim will be deemed to have been denied for the purpose of proceeding to the claim review procedure described on the next page.

APPEAL OF A CLAIM DENIAL

If there are any questions about a claim payment, the Plan Administrator should be contacted. If it is desired to initiate a claim review procedure because there is disagreement with the reasons why the claim was denied, the Plan Administrator should be notified in writing within 60 days after receipt of the written claim denial. A request for a review of the claim and examination of any pertinent documents may be made by the claimant or anyone authorized to act on his or her behalf. The reasons why it is believed that the claim should not have been denied, as well as any data, questions or appropriate comments, should be submitted in writing.

DECISION ON REVIEW

Notification of the final decision will be given 60 days after receipt of a request for review unless special circumstances, such as a Peer Review Board review of the claim, require an extension of time for processing, in which event a further 60 days will be allowed.

Revised 10/89/2500
10/90/1000
3/91/400

This booklet is a summary of the principal features of the plan.

For the LIfe and Accidental Death, Dismemberment and Loss of Sight Insurance, Group Policy No. 23821 issued to your Employer by Great-West Life is the governing document and in the event of any variation between the information in this summary and the provisions of the policy, the latter will prevail.

For the Hospital/Medical/Dental Benefits, Plan Number 52075 funded by your Employer is the governing document and in the event of any variation between the information in this summary and the provisions of the Plan Document the latter will prevail. The Plan Document governing the plan is on file in the corporate office.

This Plan is administered by

The
Great-West Life
Assurance Company

Head Office—Winnipeg, Canada
U.S. Headquarters—Englewood, Colorado